FLEXIBLE BENEFITS PLAN CLAIM FOR REIMBURSEMENT

Your Employer's Name: SATILLA REMC

Your Full Name: _____

Your Social Security Number: _____

MEDICAL CARE EXPENSES

PLEASE LIST EACH MEDICAL EXPENSE ON A SEPARATE LINE IN THE TABLE BELOW. SIGN THE FORM AND ATTACH APPROPRIATE RECEIPT DOCUMENTATION. USE MULTIPLE FORMS AS NEEDED TO RECORD ADDITIONAL EXPENSE ITEMS.

Mark the Box Describing How You Paid for Each Medical Expense	Date Medical Expense Incurred **	Medical Care Expense Description & Merchant or Provider's Name (i.e., Prescription Drug @ CVS, Doctor's Copay @ Dr. Smith, Glasses @ Pearl Vision, Contacts @ LensCrafters, Braces @ Dr. Jones, Insulin @ Walgreens, etc.) OTC MEDICATIONS MUST BE ACCOMPANIED BY A DOCTOR'S PRESCRIPTION	AMOUNT *The dollar amount entered needs to match a debit card purchase or another receipt to be reimbursed.*	Put ☒ below if this is Recurring **
☐ Paid with Benny Card ☐ NOT Paid with Card			$	☐
☐ Paid with Benny Card ☐ NOT Paid with Card			$	☐
☐ Paid with Benny Card ☐ NOT Paid with Card			$	☐
☐ Paid with Benny Card ☐ NOT Paid with Card			$	☐
☐ Paid with Benny Card ☐ NOT Paid with Card			$	☐

** An expense is considered recurring if you will use your card to pay the identical expense to the same provider on a regular basis throughout the year.

Attach Documentation For Every Expense – Incomplete Forms Will Be Rejected – See Back Of Form

I certify that: 1) each of the above medical care expenses are for services provided while I was covered under the Medical Care Flexible Spending Account, 2) all medical expenses listed above have not been reimbursed or are not reimbursable from any other source, and 3) all expenses were incurred for the medical care of me, my spouse or qualified dependent. I acknowledge that I am fully responsible for the accuracy and veracity of all information relating to this claim. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand that I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement.

Employee's Signature **Date**

YOU SHOULD KEEP A COPY OF ALL DOCUMENTATION SENT TO ADMIN AMERICA

NOTE: Claims often take several days to be processed. Therefore, claims must be received at least two business days before your scheduled processing date. You may contact Admin America or your HR staff to get your processing date.

Admin America

Mail Claims:

Admin America
P.O. Box 1209
Alpharetta, GA 30009

Fax Claims: 770-992-0723

Phone: 770-992-5959 or 1-800-366-2961

Email: claims@adminamerica.com

File Claims or Get Account Information 24/7 Via the Internet: www.adminamerica.com

Date Last Modified: 2/20/2013